State of California—Health and Human Services Agency

Department of Health Care Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Home and Community-Based Services (HCBS) Waiver Application

⇒ *Para recibir esta información en español, por favór llámenos a uno de los números siguientes: (916) 552-9105.*

To apply for one of the Medi-Cal HCBS Waivers administered by the In-Home Operations (IHO) Section, please complete this two-page application.

Applicant's Name: _____ **Home Phone** (_____) _____

Date of Birth: _____ **Age:** _____ **Male** ☐ **Female** ☐ **Married:** ☐ Yes ☐ No

County in which the applicant currently resides: _____

Where is the applicant currently residing? ☐ At home ☐ Hospital

☐ Nursing facility _____ ☐ Other _____
Facility Name and City Please specify

Mailing Address:_____ **City:** _____, **CA ZIP:**_____

Street Address:_____ **City:** _____, **CA ZIP:** _____
(If different from Mailing Address)

Medi-Cal? ☐ Yes ☐ No If yes, Medi-Cal Number: _____
(Located on the applicant's Medi-Cal Beneficiary Identification Card (BIC)

Medicare? ☐ Yes ☐ No If yes, ☐ Part A ☐ Part B ☐Part A & B ☐ Part D

Other Medical insurance? ☐ Yes ☐ No If yes, please identify: _____

List <u>current</u> medical diagnoses (main illness or injury): _____

_____

Check the boxes that identify your <u>current</u> medical needs. Use the blank spaces below to write-in your specific medical needs that are not listed. You may provide additional comments on the back of the application.

☐ Ventilator - Hours Used Per Day (hrs/day) _____
☐ Continuous Positive Airway Pressure (CPAP) Device – hrs/day _____
☐ Bi-Level Positive Airway Pressure (BiPAP) Device – hrs/day _____
☐ Respiratory Treatments - number per day _____
☐ Room Air Mist
☐ Oral (by mouth) Medications
☐ Gastric Tube (GT) Medications
☐ Intravenous (IV) Medications
☐ Chronic Pain Treatment
☐ Contractures
☐ Continuous Use of Oxygen
☐ Oral (by mouth) Feedings
☐ Gastric Tube (GT) Feedings
☐ Intravenous (IV) Nutrition
☐ Pressure Sores/Open Wounds
☐ Skin or Wound Treatments
☐ Tracheostomy
☐ Tracheal Suctioning
☐ Oral Suctioning
☐ Nasal Suctioning
☐ Oxygen As Needed
☐ Urinary Incontinence
☐ Bladder Catheterizations
☐ Bowel Incontinence
☐ Routine Bowel Care
☐ Urostomy/Colostomy
☐ Some ability to move arms or legs. Needs some help with care needs. Briefly explain on back.
☐ No movement of arms or legs. Needs total help with care needs. Briefly explain on back.
☐ Special equipment needs (ex: wheelchair, lift system, ramp). Briefly explain on back.
☐ Other_____

1501 Capitol Avenue, MS 4502; P.O. Box 997437; Sacramento, CA 95899-7437
(916) 552-9105
Internet Address: www.dhcs.ca.gov

If this application is being submitted for the applicant:

1. Was (s)he or their legal representative notified of this application for the HCBS Waiver? ☐ Yes ☐ No
2. Who has the legal authority to make the applicant's health care decisions?

☐ Applicant ☐ Other: _____ _____ (____) _____
Name Relationship Telephone Number

_____ (_____) _____ _____
Print name and title of person completing the application **Contact Telephone** **Date**

Please identify all of your current providers of service:

☐ **Home Health Agency** _____ Hours per week: _____
Agency Name and City
Type of services receiving: ☐ Attendant Care ☐ Certified Home Health Aide Nursing: ☐ RN ☐ LVN

☐ **In-Home Supportive Services (IHSS)** - Hours Authorized Per Month: _____
- *To obtain IHSS eligibility information, please contact the applicant's county Department of Social Services office and ask for the IHSS Intake Department.*

☐ **California Children's Services (CCS)** - Please describe the service(s) received:
Services: _____

☐ **Regional Center** _____ Service Coordinator: _____
Center Name Name

☐ **Adult or Pediatric Day Health Care**: _____ Days per week: _____
Center Name

Attends school outside of the home? ☐ Yes ☐ No # hours/day? _____
Does the school provide medical assistance for you? (Ex; nursing, therapy) ☐ Yes ☐ No

☐ **Multipurpose Senior Services Program (MSSP)**
- *MSSP is an HCBS waiver benefit for Medi-Cal beneficiaries over the age of 65 that provides general services and nursing support. For further information on this program, please call (800) 510-2020, or go to http://www.dhcs.ca.gov/services/ltc/Pages/MSSP.aspx.*

☐ **Hospice**
- *Hospice is a Medicare/Medi-Cal benefit for clients with a terminal diagnosis. For further information on this benefit, please contact the applicant's physician.*

☐ **Medical Case Management (MCM)**
- *MCM offers short-term medical care services for beneficiaries without other sources of health insurance. For further information, please call (916) 552-9100.*

☐ **Program of All Inclusive Care for the Elderly (PACE)**
- *PACE is a Medi-Cal benefit that provides all needed preventive, primary, acute, long-term care, social and rehabilitative services through one comprehensive program to eligible seniors, 55 years or older. For further information on this program, please call (888) 633-7223, or go to www.CalPACE.org.*

☐ **Senior Care Action Network (SCAN)**
- *SCAN Health Plan, as a Medicare Advantage Special Needs Plan, offers health and long-term care services to eligible Medicare/Medi-Cal beneficiaries over the age of 65. For further information, please call (877) 452-5898, or go to www.scanhealthplan.com.*

When completed, please return this form to IHO at the address listed below. Should the applicant relocate, have a significant change in health care needs, or change Medi-Cal insurance status, please contact IHO at (916) 552-9105.